

Performance Evaluation Report  
Inland Empire Health Plan  
July 1, 2013–June 30, 2014

Managed Care Quality and  
Monitoring Division  
California Department of  
Health Care Services

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# Performance Evaluation Report – Inland Empire Health Plan

## July 1, 2013 – June 30, 2014

### 1. INTRODUCTION

#### Purpose of Report

The Department of Health Care Services (DHCS) administers California’s Medicaid program (Medi-Cal), which provides managed health care services to more than 7.7 million beneficiaries (as of June 2014)<sup>1</sup> in the State of California through a combination of contracted full-scope and specialty managed care health plans (MCPs). DHCS is responsible for assessing the quality of care delivered to beneficiaries through its contracted MCPs, making improvements to care and services, and ensuring that contracted MCPs comply with federal and State standards.

The Code of Federal Regulations (CFR) at 42 CFR §438.364<sup>2</sup> requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the health care services provided by the states’ Medicaid MCPs. The EQRO’s performance evaluation centers on federal and state-specified criteria that fall into the domains of quality, access, and timeliness and includes designation of one or more domains of care for each area reviewed as part of the compliance review process, each performance measure, and each quality improvement project (QIP). The report must contain an assessment of the strengths and weaknesses with respect to the quality and timeliness of, and access to health care services furnished to Medicaid recipients; provide recommendations for improvement; and assess the degree to which the MCPs addressed any previous recommendations.

DHCS contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare the external quality review technical report on the Medi-Cal Managed Care program (MCMC). Due to the large number of contracted MCPs and evaluative text, HSAG produced an aggregate technical report and MCP-specific reports separately. The reports are issued in tandem as follows:

- ◆ The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*. This report provides an overview of the objectives and methodology for conducting the EQRO review. It includes an aggregate assessment of MCPs’ performance through organizational structure and operations,

<sup>1</sup> *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at:

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>.

<sup>2</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

- ◆ MCP-specific evaluation reports (July 1, 2013–June 30, 2014). Each report includes findings for an MCP regarding its organizational structure and operations, performance measures, QIPs, and optional activities, including member satisfaction survey and encounter data validation results, as they relate to the quality, access, and timeliness domains of care.

This report is specific to DHCS’s contracted MCP, Inland Empire Health Plan (“IEHP” or “the MCP”), for the review period July 1, 2013, through June 30, 2014. Actions taken by the MCP subsequent to June 30, 2014, regarding findings identified in this report will be included in the next annual MCP-specific evaluation report.

## Managed Care Health Plan Overview

IEHP is a full-scope MCP delivering services to its MCMC members as a “Local Initiative” (LI) MCP under the Two-Plan Model (TPM). In TPM counties, MCMC beneficiaries may choose between two MCPs; typically, one MCP is an LI and the other a commercial plan (CP). DHCS contracts with both plans. The LI is established under authority of the local government with input from State and federal agencies, local community groups, and health care providers to meet the needs and concerns of the community. The CP is a private insurance plan that also provides care for

Medi-Cal beneficiaries. MCMC beneficiaries in Riverside and San Bernardino counties may enroll in IEHP, the LI MCP; or in Molina Healthcare of California Partner Plan, Inc., the alternative CP.

IEHP became operational in Riverside and San Bernardino counties to provide MCMC services effective September 1996. As of June 30, 2014, IEHP had 388,712 MCMC members in Riverside County and 431,892 in San Bernardino County—for a total of 820,604 MCMC members.<sup>3</sup>

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<sup>3</sup> *Medi-Cal Managed Care Enrollment Report—June 2014*. Available at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx>

### Conducting the EQRO Review

The Code of Federal Regulations (CFR) at 42 CFR §438.358 specifies that the state or its EQRO must conduct a comprehensive review within a three-year period to determine a Medicaid MCP's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. DHCS conducts this review activity through an extensive monitoring process that assesses MCPs' compliance with State and federal requirements at the point of initial contracting and through subsequent, ongoing monitoring activities.

This report section covers review activities for DHCS's joint medical audit and its Seniors and Persons with Disabilities (SPD) medical survey. These reviews often occur independently, and while some areas of review are similar, the results are separate and distinct.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

### Assessing the State's Compliance Review Activities

HSAG organized, aggregated, and analyzed results from DHCS's medical audit/SPD medical survey reviews to draw conclusions about each MCP's performance in providing quality, accessible, and timely health care and services to its MCMC members. For this report, HSAG reviewed the most current joint medical audits/SPD medical survey reports available as of June 30, 2014. In addition, HSAG reviewed each MCP's quality improvement program description, quality improvement program evaluation, and quality improvement work plan, as available and applicable, to evaluate key activities between formal comprehensive reviews. For newly established MCPs, HSAG reviewed DHCS's readiness review materials.

### Readiness Reviews

DHCS aids MCP readiness through review and approval of MCPs' written policies and procedures. DHCS's MCP contracts reflect federal and State requirements. DHCS reviews and approves MCP processes prior to the commencement of MCP operations, during MCP expansion into new counties, upon contract renewal, and when MCPs revise their policies and procedures.

## **Medical Audits and SPD Medical Surveys**

Historically, DHCS and the Department of Managed Health Care (DMHC) collaborated to conduct joint medical audits of Medi-Cal MCPs. In some instances, however, these audits were conducted solely by DHCS or DMHC. These medical audits, which are conducted for each Medi-Cal MCP approximately once every three years, assess MCPs' compliance with contract requirements and State and federal regulations.

DHCS received authorization "1115 Waiver" from the federal government to conduct mandatory enrollment of SPDs into managed care to achieve care coordination, better manage chronic conditions, and improve health outcomes in non-County Organized Health System (COHS) counties. DHCS entered into an Interagency Agreement with DMHC to conduct health plan medical surveys to ensure that enrollees affected by this mandatory transition are assisted and protected under California's strong patients' rights laws. Mandatory enrollment for these beneficiaries began in June 2011.

During this review period, DHCS began a transition of medical monitoring processes to enhance oversight of MCPs. Two primary changes occurred. First, DHCS's Audits & Investigation Division (A&I) began transitioning its medical audit frequency from once every three years to once a year. These reviews were replaced with the A&I annual medical audit and DMHC's SPD medical survey every three years.

Under DHCS's new monitoring protocols, any deficiencies identified in either A&I medical audits or DMHC SPD medical surveys and other monitoring-related MCP examinations are actively and continuously monitored until full resolution is achieved. Monitoring activities under the new protocols include identifying root causes of MCP issues, augmented by DHCS technical assistance to MCPs; imposing a corrective action plan (CAP) to address any deficiencies; and imposing sanctions and/or penalties, when necessary.

DHCS conducted no compliance reviews with IEHP during the review period for this report. The most recent SPD medical survey with the MCP was conducted August 6, 2012, through August 9, 2012; DMHC conducted a routine medical survey during the same time frame. HSAG included a summary of these reviews in IEHP's 2012–13 MCP-specific evaluation report.

## **Strengths**

The MCP has no outstanding findings from the most recent surveys conducted by DHCS.

## **Opportunities for Improvement**

Since IEHP has no outstanding deficiencies from the most recent surveys, HSAG has no recommendations for opportunities for improvement related to compliance reviews.

### Conducting the EQRO Review

DHCS annually selects a set of performance measures for the Medi-Cal full-scope MCPs to evaluate the quality of care delivered by the contracted MCPs to Medi-Cal Managed Care program (MCMC) beneficiaries. DHCS consults with contracted MCPs, the EQRO, and stakeholders to determine what measures the MCPs will be required to report. The DHCS-selected measures are referred to as the External Accountability Set. DHCS requires that MCPs collect and report External Accountability Set rates, which provides a standardized method for objectively evaluating MCPs' delivery of services.

HSAG conducts validation of the External Accountability Set performance measures as required by DHCS to evaluate the accuracy of the MCPs' reported results. Validation determines the extent to which MCPs followed specifications established by DHCS for its External Accountability Set-specific performance measures when calculating rates.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

### Validating Performance Measures and Assessing Results

The Centers for Medicare & Medicaid Services (CMS) requires that states conduct performance measure validation of their contracted health plans to ensure that plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the plans' information systems (IS) provide accurate and complete information.

To comply with the CMS requirement, DHCS contracts with HSAG to conduct validation of the selected External Accountability Set performance measures. HSAG evaluates two aspects of performance measures for each MCP. First, HSAG assesses the validity of each MCP's data using protocols required by CMS.<sup>4</sup> This process is referred to as performance measure validation. Then, HSAG organizes, aggregates, and analyzes validated performance measure data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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<sup>4</sup> The CMS EQR Protocols can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.



## Performance Measure Validation

DHCS's 2014 External Accountability Set consisted of 14 Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>)<sup>5</sup> measures and 1 measure developed by DHCS and the MCPs, with guidance from the EQRO, to be used for the statewide collaborative QIP. Several of the 14 required measures include more than one indicator, bringing the total performance measure rates required for MCP reporting to 32. In this report, "performance measure" or "measure" (rather than indicator) is used to describe the required External Accountability Set measures. The performance measures fell under all three domains of care—quality, access, and timeliness.

HSAG performed NCQA HEDIS Compliance Audits<sup>TM6</sup> of all Medi-Cal MCPs in 2014 to determine whether the MCPs followed the appropriate specifications to produce valid rates. The audits were conducted in accordance with the *2014 NCQA HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. NCQA specifies IS standards that detail the minimum requirements that health plans must meet, including the criteria for any manual processes used to report HEDIS information. When a Medi-Cal MCP did not meet a particular IS standard, the audit team evaluated the impact on HEDIS reporting capabilities. MCPs not fully compliant with all of the IS standards could still report measures as long as the final reported rates were not significantly biased. As part of the HEDIS Compliance Audit, HSAG also reviewed and approved the MCPs' source code, either internal or vendor created, for the *All-Cause Readmissions* statewide collaborative QIP measure, since this measure is not certified under software certification for Medicaid.

## Performance Measure Validation Findings

The *HEDIS 2014 Compliance Audit Final Report of Findings for Inland Empire Health Plan* contains the detailed findings and recommendations from HSAG's HEDIS audit. HSAG auditors determined that IEHP followed the appropriate specifications to produce valid rates, and no issues of concern were identified. A brief summary of the findings and opportunities for improvement is included below.

- ◆ Due to IEHP's new clean claim initiative, the MCP received significant improvement in clean claims volume from its providers.
- ◆ IEHP successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations (i.e., processes related to enrollment, customer service, member outreach, etc.).
- ◆ HSAG's auditor noted that IEHP exercised extreme diligence with regard to data quality and control and continued its efforts to improve measure rates by offering incentives to members receiving needed services.

<sup>5</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

<sup>6</sup> NCQA HEDIS Compliance Audit<sup>TM</sup> is a trademark of the National Committee for Quality Assurance (NCQA).

- ◆ At the time of the audit, IEHP was not able to provide outcome data on the initiative it designed to ensure claims are submitted by providers within the required time frames. The auditor recommended that IEHP collect and evaluate these outcomes for future reporting.

### Performance Measure Results

After validating the MCP's performance measure rates, HSAG assessed the results. Table 3.1 presents a summary of IEHP's performance measure results for 2011–14. Note that data may not be available for all four years.

To create a uniform standard for assessing MCPs on DHCS-required performance measures, DHCS established a minimum performance level (MPL) and a high performance level (HPL) for each measure, except for utilization measures, first-year measures, or measures that had significant specification changes impacting comparability. In addition to the performance measure results from 2011–14, Table 3.1 shows the MCP's performance compared to the DHCS-established MPLs and HPLs for each year. Rates below the MPLs are **bolded**, and rates above the HPLs are shaded in gray.

DHCS based the MPLs and HPLs on the NCQA's national percentiles. MPLs and HPLs align with NCQA's national Medicaid 25th percentile and 90th percentile, respectively, except for the *CDC–H9 (>9.0 percent)* measure. For the *CDC–H9 (>9.0 percent)* measure, a low rate indicates better performance, and a high rate indicates worse performance. For this measure only, the established MPL is based on the Medicaid 75th percentile, and the HPL is based on the national Medicaid 10th percentile.

The reader should note the following regarding Table 3.1:

- ◆ The *All-Cause Readmissions* measure is a non-HEDIS measure used for the ACR collaborative QIP; therefore, no MPL or HPL is established for this measure.
- ◆ For the *All-Cause Readmissions* measure, a lower rate indicates better performance (i.e., fewer readmissions).
- ◆ The *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures are utilization measures. No MPL or HPL is established for a utilization measure. Additionally, HSAG did not compare performance for these measures.
- ◆ Although MPL and HPL information is provided, as applicable, for the following measures, DHCS did not hold MCPs accountable to meet the MPLs for the measures for 2014:
  - All four *Children and Adolescents' Access to Primary Care* measures.
  - *Cervical Cancer Screening*. Note: MCPs have reported a rate for the *Cervical Cancer Screening* measure since 2008; however, due to NCQA's HEDIS 2014 specification changes to reflect the new screening guidelines, this measure was considered to be a first-year measure in 2014. Consequently, HSAG did not include or make comparisons to previous years' rates in this report.

- *Comprehensive Diabetes Care—LDL-C Control.* (This measure is being eliminated for HEDIS 2015.)
- *Comprehensive Diabetes Care—LDL-C Screening.* (This measure is being eliminated for HEDIS 2015.)

**Table 3.1—Performance Measure Results  
IEHP—Riverside/San Bernardino Counties**

Measure <sup>1</sup>	Domain of Care <sup>2</sup>	2011 <sup>3</sup>	2012 <sup>4</sup>	2013 <sup>5</sup>	2014 <sup>6</sup>	2013–14 Rate Difference <sup>7</sup>
All-Cause Readmissions—Statewide Collaborative QIP Measure	Q, A	—	—	14.24%	14.73%	↔
Ambulatory Care—Emergency Department Visits per 1,000 Member Months*	‡	—	49.54	51.67	48.50	Not Tested
Ambulatory Care—Outpatient Visits per 1,000 Member Months*	‡	—	326.35	347.94	288.05	Not Tested
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	Q	—	84.22%	86.98%	86.33%	↔
Annual Monitoring for Patients on Persistent Medications—Digoxin	Q	—	89.45%	91.99%	90.80%	↔
Annual Monitoring for Patients on Persistent Medications—Diuretics	Q	—	83.53%	86.07%	85.42%	↔
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Q	23.88%	22.10%	22.53%	21.52%	↔
Cervical Cancer Screening	Q,A	—	—	—	70.47%	Not Comparable
Childhood Immunization Status—Combination 3	Q,A,T	69.44%	77.78%	78.24%	76.85%	↔
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	—	96.33%	96.75%	96.67%	↔
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	—	86.92%	86.91%	86.77%	↔
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	—	<b>83.53%</b>	<b>83.18%</b>	<b>84.55%</b>	↑
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	—	<b>86.30%</b>	86.72%	<b>83.97%</b>	↓
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Q	70.94%	75.76%	71.00%	62.88%	↓
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Q,A	42.31%	52.68%	59.40%	51.74%	↓
Comprehensive Diabetes Care—HbA1c Testing	Q,A	79.49%	82.98%	85.61%	84.69%	↔
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	Q	45.94%	48.72%	50.81%	46.87%	↔
Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)	Q	37.39%	38.69%	42.00%	40.60%	↔
Comprehensive Diabetes Care—LDL-C Screening	Q,A	79.70%	81.12%	83.53%	81.67%	↔
Comprehensive Diabetes Care—Medical Attention for Nephropathy	Q,A	80.34%	83.68%	84.45%	82.13%	↔
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	Q	43.80%	40.79%	36.19%	39.44%	↔
Controlling High Blood Pressure	Q	—	—	62.91%	67.56%	↔
Immunizations for Adolescents—Combination 1	Q,A,T	—	63.66%	71.99%	70.60%	↔

Measure <sup>1</sup>	Domain of Care <sup>2</sup>	2011 <sup>3</sup>	2012 <sup>4</sup>	2013 <sup>5</sup>	2014 <sup>6</sup>	2013–14 Rate Difference <sup>7</sup>
Medication Management for People with Asthma—Medication Compliance 50% Total	Q	—	—	44.25%	52.09%	↑
Medication Management for People with Asthma—Medication Compliance 75% Total	Q	—	—	21.96%	29.48%	↑
Prenatal and Postpartum Care—Postpartum Care	Q,A,T	62.94%	63.23%	59.63%	59.02%	↔
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Q,A,T	85.08%	86.42%	88.40%	86.42%	↔
Use of Imaging Studies for Low Back Pain	Q	78.42%	75.58%	77.47%	75.14%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total	Q	57.64%	77.55%	78.94%	79.86%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total	Q	65.97%	79.63%	74.54%	73.84%	↔
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total	Q	38.19%	52.78%	47.69%	53.01%	↔
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Q,A,T	74.31%	72.19%	75.69%	71.53%	↔

<sup>1</sup> DHCS-selected HEDIS performance measures developed by the National Committee for Quality Assurance (NCQA), with the exception of the *All-Cause Readmissions* measure, which was developed by DHCS for the statewide collaborative QIP.

<sup>2</sup> HSAG’s assignment of performance measures to the domains of care for quality (Q), access (A), and timeliness (T).

<sup>3</sup> 2011 rates reflect measurement year data from January 1, 2010, through December 31, 2010.

<sup>4</sup> 2012 rates reflect measurement year data from January 1, 2011, through December 31, 2011.

<sup>5</sup> 2013 rates reflect measurement year data from January 1, 2012, through December 31, 2012.

<sup>6</sup> 2014 rates reflect measurement year data from January 1, 2013, through December 31, 2013.

<sup>7</sup> Performance comparisons are based on the Chi-Square test of statistical significance with a *p* value of <0.05.

‡ This is a utilization measure, which is not assigned a domain of care.

-- Indicates the rate is not available.

↓ = Statistically significant decline.

↔ = No statistically significant change.

↑ = Statistically significant improvement.

▲ ▼ are used to indicate performance differences for the *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measures, where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant decline in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant improvement in performance, as indicated by a significant decrease of the 2014 rate from the 2013 rate.

## Seniors and Persons with Disabilities Performance Measure Results

In response to Welfare and Institutions (W&I) Code, Section 14182(b)(17),<sup>7</sup> DHCS required full-scope MCPs, effective 2013, to report a separate rate for their Seniors and Persons with Disabilities (SPD) population for a selected group of performance measures (SPD measures).

<sup>7</sup> Senate Bill 208 (Steinberg et al, Chapter 714, Statutes of 2010) added W&I Code 14182(b)(17), which provides that DHCS shall develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the subset of enrollees who are seniors and persons with disabilities. Managed care health plan performance measures may include measures from HEDIS; measures indicative of performance in serving special needs populations, such as the NCQA Structure and Process measures; or both.

Reporting on these measures assists DHCS with assessing performance related to the implementation of the mandatory enrollment of Medi-Cal only SPDs into managed care. This enrollment began June 2011 and was completed by June 2012.

The SPD measures were selected by DHCS clinical staff in consultation with HSAG and stakeholders (selection team), as part of DHCS's annual HEDIS measures selection process. The selection team considered conditions seen frequently in the senior population and reflected in measures such as *All-Cause Readmissions*, *Annual Monitoring for Patients on Persistent Medications*, and *Comprehensive Diabetes Care*. The selection team also considered measures that could reflect possible access issues which could be magnified in the SPD population, such as *Children and Adolescents' Access to Primary Care Practitioners*.

The final selected SPD measures are listed below. Following the list of measures are Table 3.2 and Table 3.3, which present a summary of IEHP's 2014 SPD measure results. Table 3.2 presents the non-SPD and SPD rates, a comparison of the non-SPD and SPD rates,<sup>8</sup> and the total combined rate for all measures except the *Ambulatory Care* measures. Table 3.3 presents the non-SPD and SPD rates for the *Ambulatory Care—Emergency Department (ED) Visits* and *Ambulatory Care—Outpatient Visits* measures. Appendices A and B include tables displaying the two-year trending information for the SPD and non-SPD populations for all measures that DHCS required the MCPs to stratify for the SPD population. The SPD trending information is included in Appendix A and the non-SPD trending information is included in Appendix B.

- ◆ *All-Cause Readmissions—Statewide Collaborative QIP*
- ◆ *Ambulatory Care—Outpatient Visits*
- ◆ *Ambulatory Care—Emergency Department Visits*
- ◆ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- ◆ *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Comprehensive Diabetes Care—HbA1c Testing*

<sup>8</sup> HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test. This information is displayed in the "SPD Compared to Non-SPD" column in Table 3.3.

- ◆ *Comprehensive Diabetes Care—LDL-C Control (<100 mg/dL)*
- ◆ *Comprehensive Diabetes Care—LDL-C Screening*
- ◆ *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

**Table 3.2—2014 Performance Measure Comparison and Results for Measures Stratified by the SPD Population for IEHP—Riverside/San Bernardino Counties**

Performance Measure	Non-SPD Rate	SPD Rate	SPD Compared to Non-SPD*	Total Rate (Non-SPD and SPD)
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.67%	17.37%	▼	14.73%
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	82.43%	88.35%	↑	86.33%
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	85.19%	91.64%	↔	90.80%
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	80.92%	87.55%	↑	85.42%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.70%	94.61%	↔	96.67%
<i>Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.81%	85.58%	↔	86.77%
<i>Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	84.46%	86.46%	↑	84.55%
<i>Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	84.06%	82.45%	↓	83.97%
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg)</i>	67.26%	60.18%	↓	62.88%
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	46.46%	56.11%	↑	51.74%
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	78.98%	87.33%	↑	84.69%
<i>Comprehensive Diabetes Care—HbA1c Control (&lt;8.0 Percent)</i>	42.48%	50.68%	↑	46.87%
<i>Comprehensive Diabetes Care—LDL-C Control (&lt;100 mg/dL)</i>	34.29%	43.21%	↑	40.60%
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.33%	85.29%	↑	81.67%
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	75.44%	89.37%	↑	82.13%
<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt;9.0 Percent)</i>	49.56%	33.71%	▲	39.44%

\* HSAG calculated statistical significance testing between the SPD and non-SPD rates for each measure using a Chi-square test.

↑ = SPD rates in 2014 were significantly higher than the non-SPD rates.

↓ = SPD rates in 2014 were significantly lower than the non-SPD rates.

↔ = SPD rates in 2014 were not significantly different than the non-SPD rates.

▲▼ are used to indicate performance differences for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* where a decrease in the rate indicates better performance.

▼ denotes significantly *lower* performance, as denoted by a significantly higher SPD rate than the non-SPD rate.

▲ denotes significantly *higher* performance, as indicated by a significantly lower SPD rate than the non-SPD rate.

Not comparable = A rate comparison could not be made because data were not available for both populations.

**Table 3.3—2014 Non-SPD and SPD Rates for Ambulatory Care Measures  
IEHP—Riverside/San Bernardino Counties**

Non-SPD Visits/1,000 Member Months*		SPD Visits/1,000 Member Months*	
Outpatient Visits	Emergency Department Visits	Outpatient Visits	Emergency Department Visits
247.47	44.44	632.06	82.89

\*Member months are a member's "contribution" to the total yearly membership.

### Performance Measure Result Findings

In 2014, IEHP had no measures with rates above the HPLs compared to two measures in 2013. The rates for two measures were below the MPLs compared to three in 2013. The rates for the following measures improved significantly from 2013 to 2014:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*; however, the rate remained below the MPL for the third consecutive year.
- ◆ Both *Medication Management for People with Asthma—Medication Compliance* measures, resulting in the rates for both measures moving from below the MPLs in 2013 to above the MPLs in 2014. Note: Since 2013 was the first year DHCS required these measures to be reported, DHCS did not hold the MCP accountable to meet the MPLs in 2013.

The rates for the following measures declined significantly from 2013 to 2014:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Use of Imaging Studies for Low Back Pain*

### Seniors and Persons with Disabilities Findings

The SPD rates for 10 measures were significantly better than the non-SPD rates, and the SPD rates for the following measures were significantly worse than the non-SPD rates:

- ◆ *All-Cause Readmissions*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

The *Ambulatory Care* measures are utilization measures, which can be helpful in reviewing patterns of suspected under- and overutilization of services; however, rates should be interpreted with caution as high and low rates do not necessarily indicate better or worse performance. For this reason, DHCS does not establish performance thresholds for these measures, and HSAG does not provide comparative analysis.

### **Improvement Plans**

MCPs have a contractual requirement to perform at or above DHCS-established MPLs. DHCS assesses each MCP's rates against the MPLs and requires MCPs that have rates below these minimum levels to submit an improvement plan (IP) to DHCS. The purpose of an IP is to develop a set of strategies that will improve the MCP's performance for the particular measure. For each rate that falls below the MPL, the MCP must submit an IP with a detailed description of the highest priority barriers; the steps the MCP will take to improve care and the measure's rate; and the specific, measurable target for the next Plan-Do-Study-Act cycle. DHCS reviews each IP for soundness of design and anticipated effectiveness of the interventions. To avoid redundancy, if an MCP has an active QIP which addresses a measure with a 2014 rate below the MPL, DHCS allows the MCP to combine its QIP and IP.

For the 2013–14 MCP-specific reports, DHCS reviewed IPs for each MCP that had rates below the MPLs for HEDIS 2013 (measurement year 2012). DHCS also reviewed the HEDIS 2014 rates (measurement year 2013) to assess whether the MCP was successful in achieving the MPLs or progressing toward the MPLs. Additionally, throughout the reporting year, DHCS engaged in monitoring activities with MCPs to assess if the MCPs were regularly assessing progress (at least quarterly) toward achieving desired IP outcomes. Finally, DHCS assessed whether the MCPs would need to continue existing IPs and/or to develop new IPs.

For MCPs with existing IPs and those needing to submit new IPs, DHCS provided HSAG with a summary of each IP that included the barriers the MCP experienced which led to the measure's rate being below the MPL, the interventions the MCP implemented to address the barriers, and outcome information. HSAG provides a summary of each IP below, along with strengths and opportunities for improvement.

Note: DHCS and the MCPs are engaging in new efforts to improve the quality of care for Medi-Cal managed care beneficiaries. These efforts include targeting key quality improvement areas as outlined in California's Medi-Cal Managed Care Quality Strategy Annual Assessment (i.e., immunization, diabetes care, controlling hypertension, tobacco cessation, and postpartum care). MCPs are using a rapid cycle approach (including the Plan-Do-Study-Act cycle) to strengthen these key quality improvement areas and have structured quality improvement resources accordingly. As a result, DHCS may not require an MCP to submit IPs for all measures with rates



below the MPLs. MCPs continue to be contractually required to meet MPLs for all External Accountability Set measures.

### **Assessment of MCP's Improvement Plans**

Although the rate for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* measure was below the MPL in 2013, the MCP was not required to submit an IP for the measure. DHCS elected not to require the MCPs to submit IPs for any of the *Children and Adolescents' Access to Primary Care Practitioners* measures for the 2013 and 2014 reporting years. This decision was made to prioritize DHCS and MCP efforts in other areas of poor performance that have clear improvement paths and direct population health impact.

In 2014, the rates for two of the *Children and Adolescents' Access to Primary Care Practitioners* measures (*7 to 11 Years* and *12 to 19 Years*) were below the MPLs. Since DHCS did not require IPs for these measures, IEHP was not required to submit IPs for any measures in 2014.

### **Strengths**

IEHP followed the appropriate specifications to produce valid performance measure rates. The HSAG auditor noted that the MCP exercised extreme diligence with regard to data quality and control and continued its efforts to increase measure rates by offering generous incentives to members receiving needed services. Additionally, the MCP successfully transitioned its Healthy Families Program population into MCMC with no impact on member operations.

The rates for three measures improved significantly from 2013 to 2014, with the improvement resulting in the rates for two measures moving from below the MPLs in 2013 to above the MPLs in 2014.

### **Opportunities for Improvement**

IEHP has the opportunity to collect and evaluate the outcomes of the initiative that it designed to ensure claims are submitted within the required time frames. The MCP also has the opportunity to assess the factors causing the rates for two measures to be below the MPLs and the factors leading to the rates for four measures to decline significantly from 2013 to 2014. By identifying the factors impacting these measures' rates, the MCP can implement strategies to improve performance on the measures. Finally, the MCP has the opportunity to assess the factors leading to the SPD rates for three measures being significantly worse than the non-SPD rates to ensure the needs of the SPD population are being met. While IEHP documented its efforts to improve the SPD rate for one of these measures (*All-Cause Readmissions*—see Appendix D), the efforts have not yet had a positive impact on the readmissions rate for the SPD population.

### Conducting the EQRO Review

The purpose of a quality improvement project (QIP) is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. HSAG reviews each QIP using the CMS validation protocol<sup>9</sup> to ensure that MCPs design, conduct, and report QIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DHCS and interested parties can have confidence in reported improvements that result from a QIP.

Full-scope MCPs must conduct a minimum of two QIPs. They must participate in the DHCS-led statewide collaborative QIP and conduct an MCP-specific (internal) QIP or an MCP-led small group collaborative QIP. MCPs that hold multiple MCMC contracts or that have a contract that covers multiple counties must conduct two QIPs for each county.

The *Medi-Cal Managed Care Technical Report, July 1, 2013–June 30, 2014*, provides an overview of the objectives and methodology for conducting the EQRO review.

### Validating Quality Improvement Projects and Assessing Results

HSAG evaluates two aspects of MCPs' QIPs. First, HSAG evaluates the validity of each QIP's study design, implementation strategy, and study outcomes using CMS-prescribed protocols (QIP validation). Second, HSAG evaluates the efficacy of the interventions in achieving and sustaining improvement of the MCP's QIP objectives (QIP results).

Beginning July 1, 2012, HSAG began using a revised QIP methodology and scoring tool to validate the QIPs. HSAG updated the methodology and tool to place greater emphasis on health care outcomes by ensuring that statistically significant improvement has been achieved before it assesses for sustained improvement. Additionally, HSAG streamlined some aspects of the scoring to make the process more efficient. With greater emphasis on improving QIP outcomes, member health, functional status, and/or satisfaction will be positively affected.

HSAG organized, aggregated, and analyzed IEHP's validated QIP data to draw conclusions about the MCP's performance in providing quality, accessible, and timely care and services to its MCMC members.

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<sup>9</sup> The CMS Protocols can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

**Quality Improvement Project Objectives**

IEHP participated in the statewide collaborative QIP and had two internal QIPs in progress during the review period of July 1, 2013–June 30, 2014.

Table 4.1 below lists IEHP’s QIPs and indicates the county in which the QIP is being conducted, whether the QIP is clinical or nonclinical, and the domains of care (i.e., quality, access, timeliness) the QIP addresses.

**Table 4.1—Quality Improvement Projects for IEHP  
July 1, 2013, through June 30, 2014**

QIP	Counties	Clinical/Nonclinical	Domains of Care
<i>All-Cause Readmissions</i>	Riverside/San Bernardino	Clinical	Q, A
<i>Attention Deficit Hyperactivity Disorder (ADHD) Management</i>	Riverside/San Bernardino	Clinical	Q, A
<i>Comprehensive Diabetes Care</i>	Riverside/San Bernardino	Clinical	Q, A

The *All-Cause Readmissions* statewide collaborative QIP focused on reducing readmissions due to all causes within 30 days of an inpatient discharge for beneficiaries aged 21 years and older. Readmissions have been associated with the lack of proper discharge planning and poor care transition. Reducing readmissions can demonstrate improved follow-up and care management of members, leading to improved health outcomes.

For most children, treatment of ADHD with psychostimulants and other psychiatric medications without appropriate follow-up visits is an indicator of suboptimal care. At the start of the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP, IEHP identified 174 children in the eligible population (17.7 percent) who did not have a 30-day follow-up visit and 47 children in the eligible population (17.0 percent) who did not have the appropriate follow-up over the subsequent nine months. IEHP’s project attempted to improve the quality of care delivered to children with ADHD and who were prescribed ADHD medications with the implementation of targeted physician interventions.

The *Comprehensive Diabetes Care* QIP targeted the MCP’s members with diabetes and focused on increasing the number of HbA1c tests, the percentage of members with an HbA1c test result less than or equal to 9 percent (indicating good control), and retinal eye exams. Ongoing management of members with diabetes is critical to preventing complications and ensuring optimal health for these members, while decreasing medical expenditures.

**Quality Improvement Project Validation Findings**

Table 4.2 summarizes the QIP validation results and status across CMS protocol activities during the review period.

**Table 4.2—Quality Improvement Project Validation Activity  
IEHP—Riverside/San Bernardino Counties  
July 1, 2013, through June 30, 2014**

Name of Project/Study	Type of Review <sup>1</sup>	Percentage Score of Evaluation Elements <i>Met</i> <sup>2</sup>	Percentage Score of Critical Elements <i>Met</i> <sup>3</sup>	Overall Validation Status <sup>4</sup>
<b>Statewide Collaborative QIP</b>				
<i>All-Cause Readmissions</i>	Annual Submission	69%	71%	<i>Partially Met</i>
	Annual Resubmission 1	100%	100%	<i>Met</i>
<b>Internal QIPs</b>				
<i>Attention Deficit Hyperactivity Disorder (ADHD) Management</i>	Annual Submission	64%	57%	<i>Partially Met</i>
<i>Comprehensive Diabetes Care</i>	Study Design Submission	44%	14%	<i>Not Met</i>
	Study Design Resubmission 1	100%	100%	<i>Met</i>

<sup>1</sup>**Type of Review**—Designates the QIP review as a proposal, annual submission, or resubmission. A resubmission means the MCP was required to resubmit the QIP with updated documentation because it did not meet HSAG’s validation criteria to receive an overall *Met* validation status.

<sup>2</sup>**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

<sup>3</sup>**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

<sup>4</sup>**Overall Validation Status**—Populated from the QIP Validation Tool and based on the percentage scores and whether critical elements were *Met*, *Partially Met*, or *Not Met*.

Validation results during the review period of July 1, 2013, through June 30, 2014, showed that IEHP’s annual submission of its *All-Cause Readmissions* QIP received an overall validation status of *Partially Met*. As of July 1, 2009, DHCS has required MCPs to resubmit their QIPs until they have achieved an overall *Met* validation status. Based on the validation feedback, IEHP resubmitted the QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score. The *Comprehensive Diabetes Care* QIP study design submission received an overall validation status of *Not Met*. IEHP resubmitted its QIP and achieved an overall *Met* validation status, with 100 percent of the evaluation elements (critical and noncritical) receiving a met score.

The *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP received an overall *Partially Met* validation status. DHCS and HSAG had discussions with IEHP and determined that this QIP

topic was no longer a priority for the MCP and that the QIP should be closed with no further validation. IEHP was not responsible for submitting any further documentation regarding this QIP.

Table 4.3 summarizes the aggregated validation results for IEHP’s QIPs across CMS protocol activities during the review period.

**Table 4.3—Quality Improvement Project Average Rates\***  
**IEHP— Riverside/San Bernardino Counties**  
**(Number = 5 QIP Submissions, 3 QIP Topics)**  
**July 1, 2013, through June 30, 2014**

QIP Study Stages	Activity	Met Elements	Partially Met Elements	Not Met Elements
Design	I: Appropriate Study Topic	90%	10%	0%
	II: Clearly Defined, Answerable Study Question(s)	80%	20%	0%
	III: Clearly Defined Study Indicator(s)	70%	30%	0%
	IV: Correctly Identified Study Population	60%	40%	0%
	V: Valid Sampling Techniques (if sampling is used)	83%	17%	0%
	VI: Accurate/Complete Data Collection	77%	14%	9%
<b>Design Total</b>		<b>78%</b>	<b>19%</b>	<b>3%</b>
Implementation	VII: Sufficient Data Analysis and Interpretation**	69%	19%	13%
	VIII: Appropriate Improvement Strategies	43%	57%	0%
<b>Implementation Total</b>		<b>61%</b>	<b>30%</b>	<b>9%</b>
Outcomes	IX: Real Improvement Achieved**	33%	33%	33%
	X: Sustained Improvement Achieved	100%	0%	0%
<b>Outcomes Total</b>		<b>50%</b>	<b>25%</b>	<b>25%</b>

\*The activity average rate represents the average percentage of applicable elements with a *Met*, *Partially Met*, or *Not Met* finding across all the evaluation elements for a particular activity.

\*\*The stage and/or activity totals may not equal 100 percent due to rounding.

Please note that the percentages for Activities I through X in Table 4.3 include the scores from IEHP’s *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP. HSAG provides no details regarding deficiencies noted during the validation process in this report since the MCP was not required to resubmit the QIP to address the deficiencies and the QIP was closed.

HSAG validated Activities I through VIII for IEHP’s *All-Cause Readmissions* annual submissions and Activities I through VI for the MCP’s *Comprehensive Diabetes Care* study design submission.

IEHP demonstrated an adequate application of the Design stage across all QIPs, meeting 78 percent of the requirements for all applicable evaluation elements within the study stage. The MCP did not document whether the study indicator rate would be compared to the goal for the

*All-Cause Readmissions* QIP, resulting in a lower score for Activity VI. The *Comprehensive Diabetes Care* QIP had multiple study design issues, resulting in a lower score for Activities I through VI. HSAG held a technical assistance call with IEHP to discuss how to improve the QIP study design and address the deficiencies. IEHP corrected the deficiencies in its resubmission, resulting in the QIP achieving an overall *Met* validation status.

The *All-Cause Readmissions* QIP is the only QIP that progressed to the Implementation stage during the reporting period. IEHP struggled with its application of the Implementation stage for this QIP, meeting 61 percent of the requirements for all applicable evaluation elements within the study stage. In the initial submission of the QIP, IEHP did not indicate if any factors threatened the internal or external validity of the findings, did not provide an interpretation of the baseline results, inaccurately documented the numerator and denominator, and did not provide the process used to evaluate the effectiveness of the interventions. The MCP corrected the deficiencies in the resubmission, resulting in the QIP achieving an overall *Met* validation status.

### **Quality Improvement Project Outcomes and Interventions**

The *Comprehensive Diabetes Care* QIP did not progress to the Implementation or Outcomes stage during the reporting period; therefore, no intervention or outcome information is included in this report.

The *All-Cause Readmissions* QIP did not progress to the Outcomes stage during the reporting period; therefore, no outcome information is included in this report. Following is a summary of the MCP's interventions for the *All-Cause Readmissions* QIP:

- ◆ Developed a process to provide timely notification to primary care providers of their members' admissions and discharges, including notification of medications at discharge.
- ◆ Enhanced the transitions of care program for all lines of business by staffing appropriately, developed an identification process to identify members at high risk for readmissions, developed targeted interventions for members transitioning from one setting to another, and addressed members' behavioral health issues.
- ◆ Created the *Knowmymeds* portal for the MCP and providers to conduct medication reconciliation.

Outcome information for the *All-Cause Readmissions* QIP will be included in IEHP's 2014–15 MCP-specific evaluation report.

Table 4.4 summarizes the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP study indicator results and displays whether statistically significant improvement was achieved over baseline and whether sustained improvement was achieved (i.e., the statistically significant improvement was maintained or improved for at least one subsequent measurement period).

**Table 4.4—Quality Improvement Project Outcomes for  
IEHP—Riverside/San Bernardino Counties  
July 1, 2013, through June 30, 2014**

<b>QIP #1—Attention Deficit Hyperactivity Disorder (ADHD) Management</b>				
<b>Study Indicator 1:</b> The percentage of eligible members who had an outpatient follow-up visit within 30 days after the Index Prescription Start Date				
<b>Baseline Period 1/1/09–12/31/09</b>	<b>Remeasurement 1 1/1/10–12/31/10</b>	<b>Remeasurement 2 1/1/11–12/31/11</b>	<b>Remeasurement 3 1/1/12–12/31/12</b>	<b>Sustained Improvement<sup>‡</sup></b>
17.7%	19.3%	22.3%*	21.0%	Yes
<b>Study Indicator 2:</b> The percentage of eligible members with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended				
<b>Baseline Period 1/1/09–12/31/09</b>	<b>Remeasurement 1 1/1/10–12/31/10</b>	<b>Remeasurement 2 1/1/11–12/31/11</b>	<b>Remeasurement 3 1/1/12–12/31/12</b>	<b>Sustained Improvement<sup>‡</sup></b>
17.0%	15.2%	21.4%**	17.4%	‡

‡ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period.

\* Statistically significant improvement from the baseline period ( $p$  value < 0.05).

\*\* A statistically significant difference between the measurement period and the prior measurement period ( $p$  value < 0.05).

‡ The QIP did not progress to this phase during the review period and therefore could not be assessed.

### ***Attention Deficit Hyperactivity Disorder Management QIP***

Although this QIP was closed, outcome information was submitted during the review period, so HSAG provides a summary of the outcomes in this report.

Although the rate for Study Indicator 1 declined during the Remeasurement 3 reporting period, the decline was not statistically significant, and the statistically significant improvement over baseline that was achieved at Remeasurement 2 was maintained. At Remeasurement 3, the QIP still had not achieved statistically significant improvement over baseline for Study Indicator 2.

As stated above, the *Attention Deficit Hyperactivity Disorder Management* QIP was closed prior to achieving a *Met* validation status since it was no longer a priority topic for the MCP; therefore, no further assessment of this QIP will be provided.

### **Strengths**

IEHP demonstrated an excellent application of the QIP Design stage for the *All-Cause Readmissions* QIP and achieved statistically significant improvement over baseline and sustained improvement for Study Indicator 1 for the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP.

## Opportunities for Improvement

IEHP has the opportunity to ensure that all required documentation is included in the QIP Summary Form since the MCP had several instances of incomplete data. The MCP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission to avoid incomplete or inaccurate documentation of the various elements.



## **Conducting the EQRO Review**

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, MCMC requires its contracted MCPs to submit high-quality encounter data. DHCS relies on the quality of these MCP encounter data submissions to accurately and effectively monitor and improve MCMC's quality of care, establish appropriate performance metrics, generate accurate and reliable reports, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of DHCS's overall management and oversight of MCMC.

Beginning in State Fiscal Year (SFY) 2012–13, DHCS contracted with HSAG to conduct an Encounter Data Validation (EDV) study. During the first contract year, the EDV study focused on an information systems review and a comparative analysis between the encounter data in the DHCS data warehouse and the data in the MCPs' data systems. For SFY 2013–14, the goal of the EDV study was to examine the completeness and accuracy of the encounter data submitted to DHCS by the MCPs through a review of the medical records.

Although the medical record review activities occurred during the review period for this report, their results and analyses were not available at the time this report was written. Individual MCP medical record review results and analyses will be included in each MCP's 2014–15 evaluation report.

### Overall Findings Regarding Health Care Quality, Access, and Timeliness

HSAG developed a standardized scoring process to evaluate each MCP in the three domains of care—quality, access, and timeliness. A numerical score is calculated for each domain of care for performance measure rates, QIP validation, and QIP outcomes (measured by statistical significance and sustained improvement). A final numeric score, combining the performance measures scores and QIP performance scores, is then calculated for each domain of care and converted to a rating of above average, average, or below average. In addition to the performance score derived from performance measures and QIPs, HSAG uses results from the MCPs’ medical audit/SPD medical survey reviews and assessment of the accuracy and completeness of encounter data to determine overall performance within each domain of care, as applicable. A more detailed description of HSAG’s scoring process is included in Appendix C.

Please note that when a performance measure or QIP falls into more than one domain of care, HSAG includes the information related to the performance measure or QIP under all applicable domains of care.

#### Quality

The quality domain of care relates to the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality as specified by the Institute of Medicine (IOM)—efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.<sup>10</sup>

DHCS uses the results of performance measures and QIPs to assess care delivered to beneficiaries by an MCP in areas such as preventive screenings and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DHCS monitors aspects of an MCP’s operational structure that support the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems. DHCS also uses the results

<sup>10</sup> This definition of quality is included in Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction: An Introduction to the External Quality Review (EQR) Protocols*, Version 1.0, September 2012. The definition is in the context of Medicaid/Children’s Health Insurance Program MCOs, and was adapted from the IOM definition of quality. The CMS Protocols can be found at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

of member satisfaction surveys to assess beneficiaries' satisfaction with the quality of the health care they receive from the MCPs.

HSAG reviewed the IEHP Quality Management Program Description and found detailed documentation of the MCP's goals and strategies for ensuring that quality care is provided to the MCP's MCMC members. Additionally, the MCP's structure for monitoring the quality of care provided to members was described.

The rates for both *Medication Management for People with Asthma* measures, which fall into the quality domain of care, improved significantly from 2013 to 2014, resulting in the rates moving from below the MPLs in 2013 to above the MPLs in 2014. The rates for the following quality measures declined significantly from 2013 to 2014:

- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ◆ *Use of Imaging for Low Back Pain*

Twelve of the performance measures stratified for the SPD population fall into the quality domain of care, and nine of these measures had SPD rates that were significantly better than the non-SPD rates. The better rates in the SPD population are likely a result of the SPD population often having more health care needs, resulting in them being seen more regularly by providers and leading to more monitoring of care. The SPD rates for the following quality measures were significantly worse than the non-SPD rates:

- ◆ *All-Cause Readmissions*
- ◆ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

All three of the MCP's QIPs fell into the quality domain of care. Only the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP reached the Outcomes stage during the reporting period. The QIP's interventions resulted in statistically significant and sustained improvement in the percentage of eligible members who had an outpatient follow-up visit within 30 days after their prescription start date, which suggests that the quality of care for these members was improved as a result of the QIP.

Overall, IEHP showed average performance related to the quality domain of care.

## Access

The access domain of care relates to an MCP's standards, set forth by the State, to ensure the availability of and access to all covered services for MCMC beneficiaries. DHCS has contract requirements for MCPs to ensure access to and the availability of services to their MCMC members and uses monitoring processes, including audits, to assess an MCP's compliance with

access standards. These standards include assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services. DHCS uses medical performance reviews, Medi-Cal Managed Care Division reviews, performance measures, QIP outcomes, and member satisfaction survey results to evaluate access to care. Measures such as well-care visits for children and adolescents, childhood immunizations, timeliness of prenatal care and postpartum care, cancer screening, and diabetes care fall under the domains of quality and access because beneficiaries rely on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

HSAG reviewed IEHP's available quality improvement information and found that the MCP included access-related goals in its quality management work plan. The MCP's annual evaluation document indicated that access to care is monitored in a variety of ways, including network status reports, grievance data, member and provider satisfaction surveys, and utilization trends.

The rates for two access performance measures were below the MPLs in 2014:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
  - The rate improved significantly from 2013 to 2014; however, the rate remained below the MPL for the third consecutive year.
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
  - The rate declined significantly from 2013 to 2014, resulting in the rate moving from above the MPL in 2013 to below the MPL in 2014.

Additionally, the rate for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure, which falls into the access domain of care, declined significantly from 2013 to 2014.

Nine of the performance measures stratified for the SPD population fall into the access domain of care. The SPD rates for five of these measures were significantly better than the non-SPD rates; and the rates for two measures, *All-Cause Readmissions* and *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*, were significantly worse.

All three of the MCP's QIPs fell into the access domain of care. Only the *Attention Deficit Hyperactivity Disorder (ADHD) Management* QIP reached the Outcomes stage during the reporting period. The QIP's interventions resulted in statistically significant and sustained improvement in the percentage of eligible members who had an outpatient follow-up visit within 30 days after their prescription start date. This positive outcome shows improvement in access to needed follow-up appointments for the QIP's targeted population.

Overall, IEHP showed below-average performance related to the access domain of care.

## Timeliness

The timeliness domain of care relates to an MCP's ability to make timely utilization decisions based on the clinical urgency of the situation, to minimize any disruptions to care, and to provide a health care service quickly after a need is identified.

DHCS has contract requirements for MCPs to ensure timeliness of care and uses monitoring processes, including audits and reviews, to assess MCPs' compliance with these standards in areas such as enrollee rights and protections, grievance system, continuity and coordination of care, and utilization management. In addition, performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to providing a health care service within a recommended period of time after a need is identified. Member satisfaction survey results also provide information about MCMC beneficiaries' assessment of the timeliness of care delivered by providers.

IEHP's quality management program description includes activities related to the areas of grievances and appeals, coordination and continuity of care, and utilization management. Each area has an impact on the timeliness of services delivered to members.

Five of the required performance measures fall into the timeliness domain of care, and the rates for all measures were between the MPLs and HPLs.

Overall, IEHP showed average performance related to the timeliness domain of care.

## Follow-Up on Prior Year Recommendations

DHCS provided each MCP an opportunity to outline actions taken to address recommendations made in the 2012–13 MCP-specific evaluation report. IEHP's self-reported responses are included in Appendix D.

## Recommendations

Based on the overall assessment of IEHP in the areas of quality, timeliness, and accessibility of care, HSAG recommends the following to the MCP:

- ◆ Collect and evaluate the outcomes of the initiative designed by IEHP to ensure claims are submitted within the required time frames.
- ◆ Assess the factors causing poor performance on the following measures:
  - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*. While the rate improved significantly from 2013 to 2014, the rate remained below the MPL for the third consecutive year.

- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years.* The rate declined significantly from 2013 to 2014, resulting in the rate moving from above the MPL to below the MPL.
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg).* The rate declined significantly from 2013 to 2014.
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.* The rate declined significantly from 2013 to 2014.
- *Use of Imaging Studies for Low Back Pain.* The rate declined significantly from 2013 to 2014.
- ◆ Assess the factors leading to the SPD rates for the following measures being significantly worse than the non-SPD rates to ensure the needs of the SPD population are being met:
  - *All-Cause Readmissions*
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- ◆ Ensure all required documentation is included in the QIP Summary Form. IEHP should reference the QIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed prior to submission to avoid incomplete or inaccurate documentation of the various elements.

In the next annual review, HSAG will evaluate IEHP's progress with these recommendations along with its continued successes.

Table A.1 provides two-year trending information for the SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP's denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the “2013–14 Rate Difference” column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table A.1—HEDIS 2014 SPD Trend Table  
IEHP—Riverside/San Bernardino Counties**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	16.95%	17.37%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	75.75	82.89	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	630.72	632.06	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	89.22%	88.35%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	91.32%	91.64%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	88.78%	87.55%	↓
<i>Children &amp; Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.12%	94.61%	↔
<i>Children &amp; Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.54%	85.58%	↔
<i>Children &amp; Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	87.66%	86.46%	↔
<i>Children &amp; Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	86.60%	82.45%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg)</i>	67.12%	60.18%	↓
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	60.59%	56.11%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	86.49%	87.33%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (&lt;8.0 Percent)</i>	57.43%	50.68%	↓
<i>Comprehensive Diabetes Care—LDL-C Control (&lt;100 mg/dL)</i>	48.65%	43.21%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	86.49%	85.29%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	86.71%	89.37%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt;9.0 Percent)</i>	31.31%	33.71%	↔

\*Member months are a member's "contribution" to the total yearly membership.



Table B.1 provides two-year trending information for the non-SPD population across the measures each MCP is required to stratify for the SPD population. The following audit findings are provided within the table:

– = A year that data were not collected.

NA = A *Not Applicable* audit finding because the MCP’s denominator was too small.

HSAG calculated statistical significance testing between the 2013 and 2014 rates for each measure using a Chi-square test and displayed this information within the “2013–14 Rate Difference” column. The following symbols are used to show statistically significant changes:

↑ = Rates in 2014 were significantly higher than they were in 2013.

↓ = Rates in 2014 were significantly lower than they were in 2013.

↔ = Rates in 2014 were not significantly different than they were in 2013.

Different symbols (▲ ▼) are used to indicate a performance change for *All-Cause Readmissions* and *Comprehensive Diabetes Care—HbA1c Poor Control* where a decrease in the rate indicates better performance. A downward triangle (▼) denotes a significant *decline* in performance, as denoted by a significant increase in the 2014 rate from the 2013 rate. An upward triangle (▲) denotes significant *improvement* in performance, as indicated by a significant *decrease* of the 2014 rate from the 2013 rate.

Not comparable = A 2013–14 rate difference could not be made because data were not available for both years, or there were significant methodology changes between years that did not allow for comparison.

Not Tested = No comparison was made because high and low rates do not necessarily indicate better or worse performance.

**Table B.1—HEDIS 2014 Non-SPD Trend Table  
IEHP—Riverside/San Bernardino Counties**

Measure	2013	2014	2013–14 Rate Difference
<i>All-Cause Readmissions—Statewide Collaborative QIP Measure</i>	9.82%	9.67%	↔
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Months*</i>	48.29	44.44	Not Tested
<i>Ambulatory Care—Outpatient Visits per 1,000 Member Months*</i>	308.23	247.47	Not Tested
<i>Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs</i>	83.14%	82.43%	↔
<i>Annual Monitoring for Patients on Persistent Medications—Digoxin</i>	96.23%	85.19%	↓
<i>Annual Monitoring for Patients on Persistent Medications—Diuretics</i>	81.24%	80.92%	↔
<i>Children &amp; Adolescents' Access to Primary Care Practitioners—12 to 24 Months</i>	96.76%	96.70%	↔
<i>Children &amp; Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years</i>	86.92%	86.81%	↔
<i>Children &amp; Adolescents' Access to Primary Care Practitioners—7 to 11 Years</i>	82.97%	84.46%	↑
<i>Children &amp; Adolescents' Access to Primary Care Practitioners—12 to 19 Years</i>	86.73%	84.06%	↓
<i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg)</i>	68.19%	67.26%	↔
<i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>	52.94%	46.46%	↔
<i>Comprehensive Diabetes Care—HbA1c Testing</i>	79.74%	78.98%	↔
<i>Comprehensive Diabetes Care—HbA1c Control (&lt;8.0 Percent)</i>	42.70%	42.48%	↔
<i>Comprehensive Diabetes Care—LDL-C Control (&lt;100 mg/dL)</i>	34.64%	34.29%	↔
<i>Comprehensive Diabetes Care—LDL-C Screening</i>	76.03%	76.33%	↔
<i>Comprehensive Diabetes Care—Medical Attention for Nephropathy</i>	75.60%	75.44%	↔
<i>Comprehensive Diabetes Care—HbA1c Poor Control (&gt;9.0 Percent)</i>	46.19%	49.56%	↔

\*Member months are a member's "contribution" to the total yearly membership.

## Quality, Access, and Timeliness Scoring Process

### Scale

2.5–3.0 = Above Average

1.5–2.4 = Average

1.0–1.4 = Below Average

HSAG developed a standardized scoring process for the three CMS-specified domains of care—quality, access, and timeliness.<sup>11</sup> This process allows HSAG to evaluate each MCP's performance measure rates and QIP performance uniformly when providing an overall assessment of *Above Average*, *Average*, or *Below Average* in each of the domains of care.

The detailed scoring process is outlined below.

## Performance Measure Rates

(Refer to Table 3.1)

### Quality Domain

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least three more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
  - ◆ If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than three.
  - ◆ If there are **three or more** measures below the MPLs, the number of measures below the MPLs minus the number of measures above the HPLs must be less than three.
3. To be considered **Below Average**, the MCP will have three or more measures below the MPLs than it has above the HPLs.

<sup>11</sup> The CMS protocols specify that the EQRO must include an assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients in its detailed technical report. The report must also document procedures used by the EQRO to analyze the data collected and how the EQRO reached its conclusions regarding the quality, timeliness, and access to care furnished by each MCP. Additional information on this topic can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

### Access and Timeliness Domains

1. To be considered **Above Average**, the MCP must not have more than two measures below the MPLs. Also, the MCP must have at least two more measures above the HPLs than it has below the MPLs.
2. To be considered **Average**:
  - ◆ If there are **two or less** measures below the MPLs, the number of measures above the HPLs minus the number of measures below the MPLs must be less than two.
  - ◆ If there are **three or more** measures below the MPLs, then the number of measures below the MPLs minus the number of measures above the HPLs must be less than two.
3. To be considered **Below Average**, the MCP will have two or more measures below the MPLs than it has above the HPLs.

### Quality Improvement Projects (QIPs)

**Validation** (Table 4.2): For each QIP submission and subsequent resubmission(s), if applicable.

1. **Above Average** is not applicable.
2. **Average** = *Met* validation status.
3. **Below Average** = *Partially Met* or *Not Met* validation status.

**Outcomes** (Table 4.4): Activity IX, Element 4—Real Improvement

1. **Above Average** = All study indicators demonstrated statistically significant improvement.
2. **Average** = Some, but not all, study indicators demonstrated statistically significant improvement.
3. **Below Average** = No study indicators demonstrated statistically significant improvement.

**Sustained Improvement** (Table 4.4): Activity X—Achieved Sustained Improvement

1. **Above Average** = All study indicators achieved sustained improvement.
2. **Average** = Some, but not all, study indicators achieved sustained improvement.
3. **Below Average** = No study indicators achieved sustained improvement.

## Calculating Final Quality, Access, and Timeliness Scores

For **Performance Measure** results, the number of measures above the HPLs and below the MPLs are entered for each applicable domain of care: Quality, Access, and Timeliness (Q, A, T); a score of 1, 2, or 3 is automatically assigned for each domain of care.

For each **QIP**, the Validation score (1 or 2), the Outcomes score (1, 2, or 3), and the Sustained Improvement score (1, 2, or 3) are entered for each applicable domain of care (Q, A, T). The scores are automatically calculated by adding the scores under each domain of care and dividing by the number of applicable elements.

The **overall Quality score is automatically calculated** using a weighted average of the HEDIS Quality and QIPs' Quality scores. The **overall Access score is automatically calculated** using a weighted average of the HEDIS Access and QIPs' Access scores. The **overall Timeliness score is automatically calculated** using a weighted average of the HEDIS Timeliness and QIPs' Timeliness scores.

Medical audit/SPD medical survey reviews do not have scores; therefore, they are not used in calculating the overall Q, A, and T scores. The qualitative evaluation of these activities is coupled with the objective scoring for performance measures and QIPs to provide an overall designation of above average, average, and below average for each domain. Additionally, the EDV study results are an indicator of an MCP's completeness and accuracy of data reporting to DHCS and are not a direct indicator of the quality, access, and timeliness of services provided to members; therefore, EDV study results are not included in the overall Q, A, and T scores.

APPENDIX D. **MCP's SELF-REPORTED FOLLOW-UP ON EXTERNAL QUALITY REVIEW RECOMMENDATIONS FROM THE JULY 1, 2012–JUNE 30, 2013 PERFORMANCE EVALUATION REPORT**

for Inland Empire Health Plan

The table below provides external quality review recommendations from the July 1, 2012, through June 30, 2013, Performance Evaluation Report, along with IEHP's self-reported actions taken through June 30, 2014, that address the recommendations. Neither HSAG nor any State agency has confirmed implementation of the actions reported by the MCP in the table.

**Table D.1—IEHP's Self-Reported Follow-Up on External Quality Review Recommendations from the July 1, 2012–June 30, 2013 Performance Evaluation Report**

2012–13 External Quality Review Recommendation Directed to IEHP	Actions Taken by IEHP During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
<p>1. Assess the factors that are leading to the rate on the <i>Children and Adolescents' Access to Primary Care Practitioners (7–11 Years)</i> measure being below the MPL and identify interventions that will result in an improvement on performance.</p>	<p>Rates were continuously monitored on a monthly basis and followed by an internal multi-departmental team (HEDIS Improvement Committee). Member newsletter articles were created discussing the importance of well-child exams. As part of the annual Evidence of Coverage (EOC) mailing packets, IEHP provided a summary of prevention services needed, tailored to the member (including annual primary care physician (PCP) visits). Statistically significant improvement was seen in this rate in HEDIS 2014 compared to HEDIS 2013 (<math>p &lt; 0.05</math>).</p>
<p>2. Assess the factors that are leading to a significantly higher rate of readmissions for the SPD population when compared to the non-SPD population and identify strategies to ensure the MCP is meeting the needs of the SPD population.</p>	<p>In the past two years, IEHP has seen a significant increase in SPD members (Seniors and Persons with Disabilities) who as a group have a higher rate of chronic conditions than the Temporary Assistance for Needy Families (TANF) population and higher rate of acute hospital utilization. The SPD and non-SPD populations are distinct populations with little comparability, especially as it relates to demographic information and morbidity and prevalence of chronic conditions, including utilization of medical services. SPD members have acute bed day rates that are over three times higher than the non-SPD membership. Emergency room utilization is also higher (two times) compared to the general Medi-Cal membership.</p> <p>The diagnostic conditions of the SPD membership also reflect a sicker population compared to the TANF membership, with top conditions driving admissions among the SPD membership including chronic renal failure, schizophrenia and other psychotic disorders, hypertension, rehabilitation care, diabetes, bipolar disorders, and other connective tissue diseases.</p> <p>The health plan has weekly inpatient rounds/case conferences, which include the inpatient nurses and the medical directors, in the Utilization Management department. During these meetings, any members admitted to a facility, including SPD members, are</p>

2012–13 External Quality Review Recommendation Directed to IEHP	Actions Taken by IEHP During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
	<p>discussed, and those determined to require additional intervention and/or assistance through the care transition process are referred to the Transition of Care team to assist with coordination of care and follow-up. The UM department has a Transition of Care team and a SMART (specific, measureable, achievable, relevant, time-bound) team (special mobile response team) whose responsibility is to provide intensive case management of high-risk and high-need members. These teams help to intervene with members who are showing specifically high-cost, high-risk patterns by visiting them in the facility (inpatient hospital or skilled nursing facility) or in the home (or another alternative setting). The goal of the team is to assist high-risk, high-cost members to reduce hospitalization and readmissions and provide efficient utilization management of medical services.</p>
<p>3. Ensure the following related to QIPs:</p>	
<p>a. Provide accurate calculation and reporting of <math>p</math> values on the QIP Summary Form.</p>	<p>IEHP will report the <math>p</math> value as <math>&gt;</math> or <math>&lt;</math> 0.05, instead of reporting the actual <math>p</math> value. IEHP will use an appropriate statistical test to generate the <math>p</math> value as described in the QIP.</p>
<p>b. Provide a complete, detailed description of the data collection process and data analysis plan for all QIPs.</p>	<p><b>Data Collection Process:</b> Eligible members are identified from claim, encounter, and/or pharmacy data. IEHP uses all available data sources to identify members for inclusion into the study population. Data collection is ongoing and is aggregated annually for reporting. Additional numerator data may be received from claims, encounters, or medical records.</p> <p><b>Data Analysis Plan:</b> The rates for QIP measures are calculated for IEHP using an NCQA-certified HEDIS software vendor, Inovalon—Quality Spectrum Insight (QSI), when applicable. IEHP’s Database Team populates the HEDIS Repository in January of each year with the eligibility and utilization data from the prior year and loads into QSI. Compliance rates are generated within QSI following the measure specifications. A health care informatics analyst exports rates and loads into SPSS software for statistical analysis.</p> <p>SPSS is used to compare study results from the baseline to measurement periods. The appropriate statistical test is used to compare the rates from the baseline to remeasurement periods. A <math>p</math> value of <math>&lt;</math>0.05 is set as the standard for determining statistical significance. Each measurement period will be compared to the corresponding measurement period goal, the previous measurement period, and the baseline measurement. Prior to report finalization all rates and statistical analysis are reviewed by the Health Care Informatics and the Quality Management departments. Findings are shared annually in the Quality Improvement Subcommittee meetings. IEHP’s director of quality management and director of health care informatics are responsible for reviewing and approving final rates for all QIPs.</p>

2012–13 External Quality Review Recommendation Directed to IEHP	Actions Taken by IEHP During the Period July 1, 2013–June 30, 2014 that Address the External Quality Review Recommendation
<p>c. Monitor and evaluate interventions to determine if the interventions have positively affected the QIP outcomes. Interventions that are deemed successful in improving the outcomes should be standardized and monitored for continued success.</p>	<p>IEHP monitors rates on a quarterly basis to evaluate the impact of interventions. HEDIS rates are reviewed monthly by the HEDIS Improvement Committee, and quarterly updates are provided to the Quality Improvement Subcommittee. Based on the rates reviewed, interventions are proposed and developed. New interventions are piloted with a targeted group, evaluated for success, and revised as needed prior to rolling out on a larger scale.</p>
<p>4. Review the 2013 MCP-specific CAHPS<sup>12</sup> results report and develop strategies to address the <i>Rating of Personal Doctor</i>, <i>How Well Doctors Communicate</i>, and <i>Rating of All Health Care</i> priority areas.</p>	<p>IEHP formed an internal CAHPS Improvement Committee whose focus is to develop strategies for improving IEHP's CAHPS performance in all lines of business. IEHP has the following interventions in development: Customer Service Training, internal PCP-level CAHPS survey tool, Motivational Interviewing Training, and a focus member group to provide feedback on survey tools and results.</p>
<p>5. Review the 2012–13 MCP-Specific Encounter Data Validation Study Report and identify strategies for addressing the recommendations to ensure accurate and complete encounter data.</p>	<p>Long Term Care (LTC) submissions—IEHP is currently submitting LTC records as part of hospital encounter submissions. As part of IEHP's encounter data processing system replacement, we will be utilizing the 5010 837 format that will clearly identify the LTC records.</p> <p>Regarding Monitoring of Medical and Hospital submission volumes, IEHP is enhancing reporting encounter data capabilities to include monitoring of the outbound encounter data submission process.</p> <p>Regarding Rendering Provider Number, IEHP is in the process of implementing a validation rule that requires all inbound encounters to include Rendering National Provider Identifier (NPI). This validation rule was not enforced during the audit period.</p>

<sup>12</sup> CAHPS® refers to Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).